Protocol Modifications: When/Why/How?

In some instances, PE or CPT has been combined with other treatments to serve clients with mental health issues that would significantly interfere with treatment using the DBP alone. Modifications with support in the treatment literature include (but are not limited to):

- **STAIR-Complex PTSD/BPD**
- **DBT/PE-BPD**
- **PE with co-morbid alcohol dependence (COPE and others)**
- **Individuals with TBI**
- **Psychotic Disorders** - Notably, in data recently presented at ABCT and subsequently published, Agnes van Minnen et al., gave standard PE to patients with a psychotic diagnosis with excellent outcome and no adverse events associated with the treatment so it is not necessary to always jump to modify.

Modifications with anecdotal support, and few if any theoretical concerns that would discourage their use:

- **PE or CPT with co-morbid panic disorder**
- **Learning disability or developmental delay**
- **Social, or functional skills deficits such as Emotion regulation, Distress tolerance, Interpersonal effectiveness**

These modifications are **PLANNED**, and are implemented based on a thorough assessment of the patient prior to beginning treatment, or soon after the additional condition or circumstance is uncovered. They tend to affect the entire protocol in a systematic way, or involve addition of modules specific to the problem, as in the case of STAIR or COPE for example.

How to implement a planned modification:

- Select based on your initial assessment
- Choose to augment treatment with interventions that address symptoms or behaviors that interfere with treatment :

Some examples:

  - Co-morbidities
  - Skill or knowledge deficits
  - Literacy
  - Atypical Learning Style
  - Medical conditions
  - Access to treatment or schedule as required by standard protocol

In other cases, the need for modification arises in the course of treatment as the patient evidences difficulty making improvements, or working within the protocol.
Some of these modifications are not really modifications of the standard protocol at all, but are part of the original treatment. Many of these are covered in the treatment manuals for example, manipulating open or closed eyes to help a patient titrate engagement during

imaginal exposure. Others may be common sense modifications that are implemented as a difficulty arises, for example, using the visual chronic pain scale with the smiling and sad faces rather than the 0-100 SUDs scale, for patients that find the numbers distracting or difficult (Downs syndrome, TBI); or setting up appointment reminders for a patient with TBI.

Still others may be less intuitive and require more thought and consultation to insure that they are theoretically appropriate and will not violate the intent of the treatment protocol. These include working with patients on some types of medications, Manipulating safety behaviors within the in vivo hierarchy, and modifying procedures when the patient is extremely sensitive and resistant to distress, for example, using writing instead of verbal recounting to begin the imaginal exposure, or walking while talking to manage dissociation during session. These modifications may be appropriate at times, but can also represent collusion with avoidance, or poor theoretical understanding on the part of the therapist. For these reasons, it is important to consult with other EBP providers to make sure modifications are theoretically sound and clinically appropriate.

The extent to which the provider deviates from the protocol without theoretical and evidentiary support, affects the confidence with which comparable results can be expected, so modifications should not be taken lightly, but neither should they be avoided if there is no other means by which a patient may access the treatment. Sometimes modifications are the only things that make it possible for the patient to receive treatment, for example, patients down range, or patients with a schedule that prevents standard timing and scheduling.

When and how to implement ad hoc modifications
Select based on patient response to standard treatment. First and foremost, check the protocol. Did the client receive an adequate trial of the standard EBP?

- Modify if:
  - Patient is unable to engage in treatment procedures as written
  - Symptoms remain high after standard course
  - Patient evidences some progress but cognitive distortions continue to impair functionality (e.g., guilt)
  - Patient evidences some progress but has persistence of particular symptoms (e.g., insomnia, nightmares)

Examples of ad hoc modifications include the following:

Client is unable to engage in treatment procedures:

- Under or overengagement, anger – Validate anger, Psychoeducation about anger, Modify imaginal instructions to bypass anger
- Low IQ/reading level -Modify forms for readability, Use simpler SUDs scale
- TBI- Modify procedures to include reminders, alarms, more written materials, inclusion of a coach or partner

Symptoms remain high after an adequate trial of the EBP

- Revisit the primary problem list
- Try different EBP
- Add medication
- Consider life events that may impair engagement, focus

Some progress but sx continue to impair

- Is there an additional trauma – Additional Treatment focusing on other traumas using PE
- Are there residual cognitions that continue to impair progress – More formal Cognitive restructuring
- Nightmares – nightmare protocol Imagery Rescripting and Reprocessing Treatment
- Insomnia – CBT-I